BIBLIOGRAPHY.

✓ 1. Budd. Disease of the Liver, 1857.

o 2. Cohn. Klinik der embolischen Gefässkrankheiten, Berlin, 1860.

✓ 3. Frerichs. Klinik der Leberkrankheiten, Braunschweig. 1861. Bd. ii.

✓ 4. Rosenblatt. Ueber einen Fall von abnormem Verlauf der Lebervenen, Inaug. Dissert., Würzburg, 1867.

5. Gee. Complete Obliteration of the Mouths of the Hepatic Veins, St. Bartholomew's Hospital Reports, 1871, vol. vii.

✓ 6. Schüppel. Die krankheiten der Venæ Hepaticæ, Handbuch der spec. Path. u. Therap., v. Ziemssen, 1880, Bd. viii. vol 9

o 7. Hainski. Ein Fall von Lebervenen obliteration, Inaug. Diss., Göttingen, 1884.

o 8. Lange. Ibid., Kiel, 1886.

9. Kelynack. Stenosis of Hepatic Vein with Intrahepatic Thrombosis, Medical Press and Circular, London, 1897, vol. cxv., No. 25.

10. Chiari. Ueber die selbständige Endophlebitis obliterans der Hauptstämme der Venæ Hepaticæ als Todesursache, Ziegler's Beitr., 1899, Bd. xxvi pp. 1–18.

✓ 11. Churton. A Case of Cirrhosis of Liver apparently due to Congenital Syphilis with Thrombosis of Hepatic Veins, Transactions of the Pathological Society of London, 1899, vol. l. pp. 145, 146.

✓ 12. Lazarus-Barlow. Ibid., p. 146.

o 13. Thran. Ueber einen Fall von Lebervenen Thrombosis, Inaug. Diss., Kiel, 1899.

✓ 14. Quincke. Diseases of the Liver, Pancreas, and Suprarenal Glands, Quincke and Hoppe Seyler in Nothnagel's Encyc., Amer. ed., 1903, p. 903.

✓ 15. Lichtenstern. Ueber einen neuen Fall von selbständiger Endophlebitis obliterans der Hauptstämme der Venæ Hepaticæ, Prager med. Woch., 1900, pp. 325–327, 338–339.

o 16. Kretz. Neisser's Stereoskopisch-medicinischer Atlas, No. 36, Leipzig, 1900.

✓ 17. Rendu et Poulain. Phlébite oblitérante d'une grosse Veine sus-hepatique; Apoplexie Hepatique, Bulletins et mémoirs de la Société médicale des hôpitaux de Paris, 6 Juin, 1901.

✓ 18. Penkert. Ueber idiopathische Stauungsleber (Verschluss der Venæ Hepaticæ), Virchow's Archiv, 1902, Bd. clxix. pp. 337–359.

o 19. Moore. Primary Obliterative Inflammation of the Main Trunk of the Hepatic Veins, Medical Chronicle, Manchester, July, 1902.

✓ 20. Kretz. Pathologie der Leber, Lubarsch-Ostertag Ergebnisse Allgem. Path. Abtheilung 2, Jahrgang 8, p. 498, 1904.

o 21. Fabris. Sulla Occlusione e trombosi delle vene epatiche, Archiv per le Sc. Med., 1904, Bd. xxviii. p. 221.

o 22. Meystre. Un Cas de Thrombose des Veines Hepatiques, Trav. de l'Institut de Stilling, Lausanne, 1904.

✓ 23. Rolleston. Diseases of the Liver, Saunders & Co., 1905.

A CASE OF EXCISION OF THE HEAD OF THE HUMERUS FOR CONGENITAL SUBACROMIAL DISLOCATION OF THE HUMERUS.[1]

By John B. Roberts, M.D.,

of Philadelphia.

A boy, aged three years, was operated upon on December 5, 1903. The head of the bone could be seen and felt under the acromial process, and the humerus was firmly abducted from the chest with the external condyle pointing almost directly forward instead of outward. The position of the arm and attached forearm was due to the rotation of the humerus, caused by the displacement of the head of the bone. Voluntary elevation of the arm was impossible and other movements were restricted. It was, therefore, deemed advisable to attempt replacement of the head of the bone by operation, and in case of failure, to excise the humeral head. A vertical incision, three inches long, was made over the prominence below the acromion, through the fibres of the deltoid. The round head of the bone was covered by a deeper muscle, which was probably the infraspinate. After opening the capsule and exposing the head, attempts were made to reduce the dislocation. As reduction was

---

[1] Read by title at the meeting of the American Surgical Association, July 5, 1905.

FIG. 1

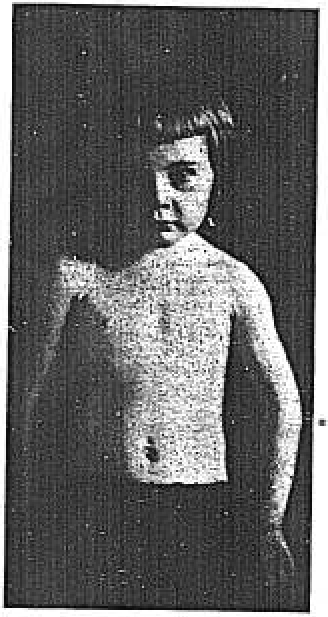
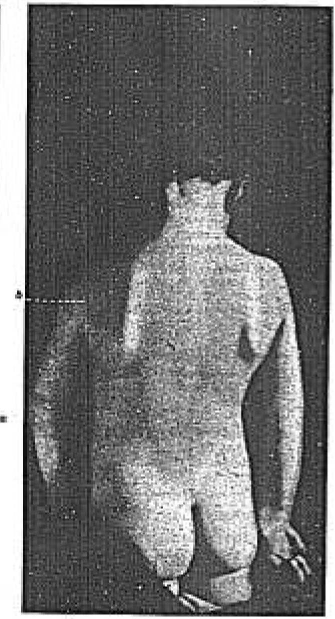


FIG. 2



Congenital subacromial dislocation of the left humerus. Boy, aged three years. Observe abduction and inward rotation of humerus. Before operation. *a*. Olecranon points directly outward and external condyle forward. *b*. Head of humerus.

impossible, an incision about three inches long was made in a vertical direction through the deltoid on the front of the shoulder and carried down to the deep layers of muscle. Counterpressure upon the bone was made here in the endeavor to aid in the reduction of the luxation. All these efforts were unavailing. The glenoid cavity itself was not exposed, because of the depth of the wound and the youth of the child. The condition seemed to make it evident that only a prolonged and bloody dissection would thoroughly expose

FIG. 3

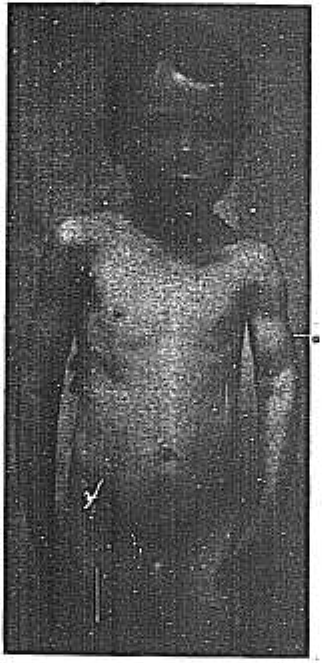
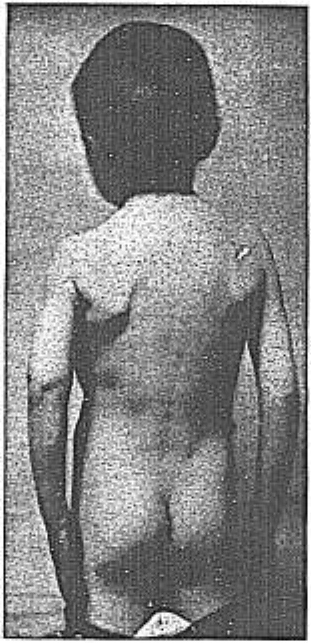


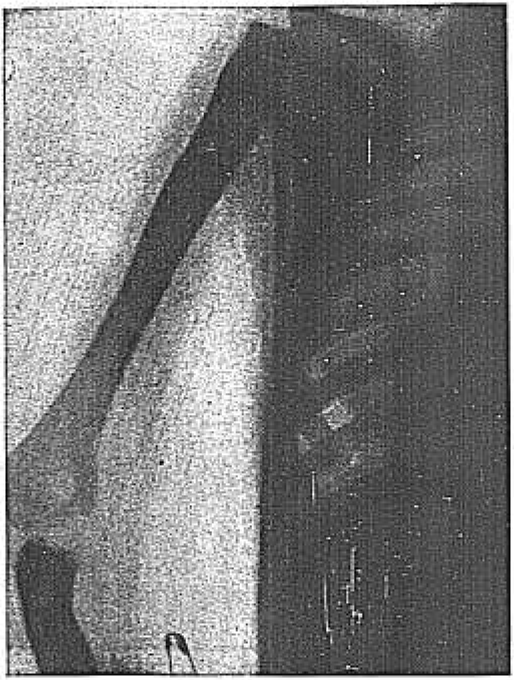
FIG. 4



Congenital subacromial dislocation of left humerus. Same patient as Fig. 1. Photograph taken about eighteen months after excision of head of the humerus. Observe improved position of elbow, but the shortening of humerus. *a.* Body of biceps unnaturally prominent because origin of one head is lost.

the glenoid cavity. I therefore came to the conclusion that excision of the head of the bone would give probably as good, if not a better, joint with less risk. Reduction with stiffness of the joint seemed to me to be but little better than the present condition. The head of the bone was thoroughly exposed and excised through the posterior wound. The section was made with a small saw close to the head, so as to remove as little as possible of the shaft. In removing the excised fragment the long head of the biceps was divided in the

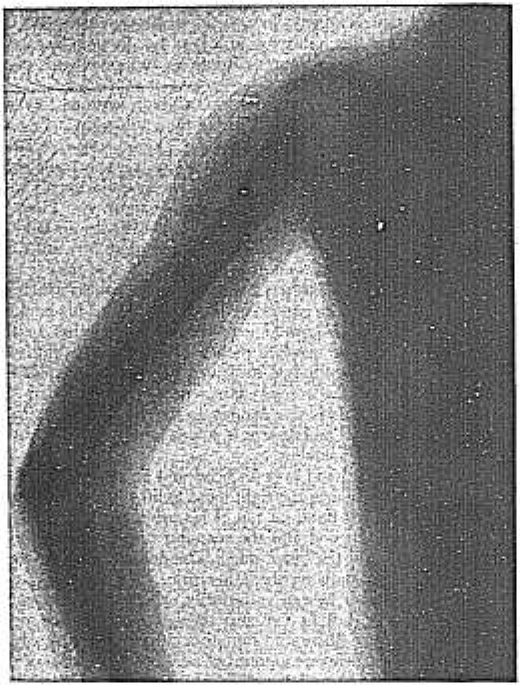
FIG. 5



Congenital subacromial dislocation of the left humerus. Same patient as Fig. 1. Observe abduction rotation of humerus, shown by the elbow being held away from the thorax, with olecranon pointing outward.

depth of the wound close to the axilla. The rotation of the bone caused the bicipital groove and its enclosed tendon to be almost directly opposite the incision made on the back of the joint. The

FIG. 6



Congenital subacromial dislocation of the left humerus. Same patient as Fig. 1. Skiagraph taken about three months after excision of the head of the humerus. Observe the absence of abnormal rotation of the humerus, which is seen in the skiagraph taken before operation. The abduction of the humerus seen here is voluntary.

division of this muscle was not recognized at the time. Both cuts were closed without drainage and the forearm supported by a sling. Union occurred by first intention.

When seen on March 2, 1904, the motion of the arm was good, though the limb was weak. The child had a tendency to aid it by lifting it with the right hand when told to raise it. He could touch the ear on both sides and the back of the head with the left hand if the arm is aided a little with his own right hand or an attendant's hand. This aid is needed especially when he touches the right ear. His mother said that he always helped the dislocated arm with the other hand, and that this habit was still kept up, though there was much less need of such assistance. Frictions and calisthenic exercises were recommended.

When examined June 1, 1905, the notes made were as follows: The left humerus is considerably shorter than the right. Passive motion elicits grating at the shoulder-joint. There is possible moderate rotation, though it is not as complete as on the right side. Elevation of the humerus is restricted, and the scapula moves with the humerus, if passive movements are at all extensive. There is still some rotation forward of the humerus when the arm is held at rest, so that the external condyle presents rather more forward than in the normal arm. The boy can now touch the back of his ear and neck on the left side. He can put his hand to his mouth, which he could not do before, and he can clasp his hands behind his back in the lumbar region. The normal arm from the acromion to the external condyle is six and one-half inches long. The left arm from the acromion to external condyle measures five and three-quarters inches. The belly of the biceps stands out prominently in the middle of the arm. This is due largely to the division of its long head at the operation. The forearm is somewhat atrophic, and the left hand seems slightly smaller.

He cannot lift the left hand over his head, but he can nearly touch the occipital region. He uses the right hand to lift the left arm when he desires to put the left hand on top of his head.

His general health is good and the scapular muscles seem about as well developed as on the other side. The deltoid seems to be a little more prominent than on the other side.

It is doubtful whether he can voluntarily bring the left elbow in contact with his ribs, but he can put the left hand on the right shoulder and bring the elbow and humerus close to the ribs. It is difficult to determine the exact amount of adduction, because of the youthfulness of the child and the difficulty of making him understand.

The deformity of which this case is an illustration is unusual. There has been considerable discussion as to how many of such cases are traumatic dislocations caused by injuries at the time of delivery. I see no reason to doubt that a large proportion of them are the result of intrauterine conditions. Accidental subspinous or subacromial luxations are so rare in both adults and children that it seems to me reasonable to look upon them, when found immediately after birth, as true congenital conditions. It is true that violence during delivery may cause the lesion, and also that such displacements may be the result of a muscular paralysis occurring before birth or during delivery. It is quite possible, therefore, that some of the cases reported belong to these groups. The occurrence of this posterior displacement occasionally in both shoulders of the same infant and at times in more than one child of the same family is strong evidence, in my opinion, of the prenatal origin of the bony abnormality. I have not been able to find many cases recorded in the literature which bear rigid analysis. Stimson[1] says that he has seen 4 or possibly 5 cases. Phelps had seen, according to Stimson, 6 or 7. Scudder[2] reports 2; Küster,[3] 1 bilateral case; Gaillard,[4] 1; R. W. Smith,[5] 1 bilateral case; Cumston,[6] 1; Peckham,[7] 2; and I reported a previous case ten years ago to this Association.

VOLVULUS OF THE CÆCUM AND ASCENDING COLON.

By Alfred C. Wood, M.D.,
OF PHILADELPHIA,
ASSISTANT PROFESSOR OF SURGERY, UNIVERSITY OF PENNSYLVANIA; SURGEON TO THE UNIVERSITY, PHILADELPHIA, AND ST. TIMOTHY'S HOSPITALS.

Mrs. O. B., aged thirty-four years, widow (Philadelphia Hospital, No. 1756), was admitted from the out-wards on account of severe abdominal pain and vomiting, September 14, 1903.

Her statement was as follows: On the evening of September 13, 1903, she lifted a heavy woman into bed, and afterward "felt badly," although she did not report the matter and did not do anything to get relief. About 11 o'clock on the following morning she felt a sudden, very sharp, lancinating pain in the abdomen. The pain continued, was paroxysmal in character, and was so severe as to cause her to cry out; it seemed distributed equally over the abdomen. Vomiting began soon after the pain, and has since been almost continuous. The bowels acted regularly and normally until the

---

[1] Fractures and Dislocations, ed. 1905, p. 606.

[2] Archives of Pediatrics, 1890, vii. p. 260.

[3] Ein Chirurgisches Triennium, 1882, p. 256; also in Berlin. klin. Woch., January 6, 1879, Bd. i. p. 9.

[4] Mém. de l'acad. de méd., 1841, p. 703; quoted fully by Alph. Robert in Des vices congénitaux de conformation des articulations, Paris, 1851, p. 53.

[5] An Essay upon the Original or Congenital Luxations of the Upper Extremity of the Humerus, Dublin Medical Journal, 1839, vol. xv. p. 249; also mentions the case in his Treatise on Fractures, Dublin, 1854, p. 256.

[6] The American Journal of the Medical Sciences, June, 1903.

[7] American Journal of Orthopedic Surgery, April, 1905, p. 386.